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ABSTRACT

This background paper on refugee needs assessment discusses the assumptions, goals, objectives, strategies, models, and methods that the state refugee programs can consider in designing their strategies for assessing the mental health needs of refugees. It begins with a set of background assumptions about the ethnic profile of recent refugee populations and the unique aspects of these refugees' experience. The next section defines the needs assessment as a policy tool and lists its purposes in relation to the intended users: policymakers, administrators and managers, planners, clinicians, advisory committees and groups, and consumers. The third section discusses needs assessment in the specific context of a state refugee mental health delivery system. It is noted that such an assessment must consider the system's community environment, the rules (statutes, procedures, case law, and conventions) under which it operates; its administrative structure; its financing; its facilities and equipment; its programs; its staff; and its consumers. The fourth section enumerates the major models and methods of needs assessment that state programs may employ, and provides general comments on their appropriateness for assessing the mental health needs of refugees. Methods discussed include the use of social indicators, key informants, public forums, rates in service, surveys, and data analysis. A bibliography is included. (TE)

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REFUGEE ASSISTANCE PROGRAM - MENTAL HEALTH

TECHNICAL ASSISTANCE CENTER

TASK II - NEEDS ASSESSMENT

MODELS AND METHODS FOR ASSESSING REFUGEE MENTAL HEALTH NEEDS

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REFUGEE ASSISTANCE PROGRAM - MENTAL HEALTH

TECHNICAL ASSISTANCE CENTER

TASK II NEEDS ASSESSMENT

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This is a background paper on refugee needs assessment, prepared by the Technical Assistance Center in accordance with NIMH Contract No. 278-85-0024(CH). It discusses the assumptions, goals, and objectives, strategies, models and methods that the state refugee programs can consider in designing their strategies for assessing the mental health needs of refugees.

Preparation of this background paper is the first of three parts of the needs assessment task to be performed by the Center. The other two are: to act as broker among the states on needs assessment methodology; and to provide consultation to the state refugee programs on identifying gaps in the service delivery system.

Some refugee-specific background is necessary, however, before considering the technical aspects of needs assessment.

I. ASSUMPTIONS

Although the term refugee means a person who has fled or been expelled from his or her country or place of usual or preferred

residence for reasons of race, religion, nationality or politics and he or she is an immigrant to the new country or place of settlement, the refugee populations of concern in this project differ from immigrants and refugees of the past in important ways. These differences have to be considered in designing needs assessment strategies and in developing mental health and human service delivery systems to serve refugees.

A. The refugee populations.--Although immigrants, including refugees, have arrived in large numbers in the past, they were predominantly Caucasian Europeans who emigrated voluntarily to seek better opportunities or who fled persecution in Russia and Nazi Germany or Communist oppression in countries such as Poland, Hungary, and Czechoslovakia. Racially and culturally, these refugee immigrants were not unlike the mainstream of immigrants of the past, mainly Caucasian Europeans.

More recent immigrants, of whom recent refugees are a special group, differ from past immigrants and refugees in that they are mainly from Central and South America, the Caribbean, and Asia, with a few from Afghanistan and certain African countries such as Uganda and Ethiopia. The new immigrants and refugees are racially and culturally different from the earlier immigrants and refugees: they are nonwhite, usually not of the Judeo-Christian religion and heritage, speak a non-European language, have a non-western history, culture and tradition, and may have a different concept of family and relationships to employers, government and other societal institutions.

B. The Refugee Experience.-- Needs assessment and service strategies need to take into account the unique situations of recent refugee immigrants:

1. They are immigrants. As a consequence, until or unless they qualify for U.S. citizenship, they are legal aliens and are affected by federal laws applying to non-citizens as well as some state laws. Ordinarily, they will have some kind of relationship with the Immigration and Naturalization Service. They cannot vote or hold public office and, hence, are barred from the usual rights, duties and privileges of citizenship. As aliens, they will be disqualified from many jobs that require citizenship. Many scholarships, fellowships and grants require citizenship, although permanent residency may be sufficient (the "green card"). Some refugees are illegal immigrants, such as Haitians who have fled their country and landed in the U.S. without authorization. As illegal aliens, they are subject to arrest, detention, and possible deportation. Hence, they may seek or be restricted to jobs in the underground economy where detection is less likely. (They are obviously not likely to participate in needs assessment surveys or seek out help from mainstream health and social agencies where detailed personal histories are normally taken.)

2. They are refugees. They have left involuntarily or have been forcibly expelled from the country or place they consider their home. Most have suffered intense trauma prior to and during their migrations, often over a period of years before being admitted to the U.S. Many have been brutalized, witnessed the deaths of family members, relatives and friends, been separated from kin, and languished in refugee camps under the most primitive conditions. Virtually all have lost all of their resources and arrive in the U.S. penniless.

3. Most are racial minorities of color. From being a member of the racial majority or of a population group that is not clearly set off

from the others by physical characteristics, they suddenly become minorities and suffer from discrimination and disfavoring that affect other racial minorities of color in the U.S.: Blacks, Hispanics, American Indians, and Pacific-Asians. Thus, most refugees are subject to two kinds of racism:

a. Personal racism, meaning prejudices, biases, stereotypes, and hatreds that are blatant, overt, and openly directed at minorities of color. Although there is the popular stereotype of Asians as quiet, law-abiding, studious and hardworking, there are opposite stereotypes of clannishness, secretiveness, non-conforming (ignoring of fishing areas and quotas), "living like pigs" and "breeding like rats." Among youth, fights have broken out between Asian refugee youth, often unaccompanied minors of high school age, and their white classmates.

b. Institutional racism, meaning the way policies, programs, and practices operate to disfavor individuals on the basis of race,a more subtle form of racism but one that is pervasive and devastating. Thus, because racial minorities, including many refugees, are disproportionately represented in the "secondary" labor market characterized by irregular, lower-paying jobs with few or no fringe benefits, they are systematically discriminated against in social security (a very high proportion of income taxed but lower benefits because of the earnings-related benefit formula), unemployment compensation (which requires a prior work history in covered employment and benefits are calculated as a percentage of the prior wage), health care (because the elderly and disabled often cannot qualify for Medicare and those in the labor force often are in jobs that do not include employer-provided health plans), and innumerable forms of

"credentialism" that may bar refugees, as well as other minorities, from education, jobs, and other opportunities. Because they cannot qualify for benefits and services that the majority can, minorities, including many refugees, must apply for and receive programs that go under the rubric of "welfare": AFDC, Food Stamps, Medicaid, Public Housing, Housing Assistance, Low Income Energy Assistance, and free school lunches. All of these programs are heavily stigmatized, require a "means test" to prove eligibility, generally have meager benefits and onerous procedures, and are demoralizing to recipients.

With respect to refugee needs assessment and service delivery systems, office hours and locations, treatment models based on the white, middle-class culture and values, and language barriers are all forms of institutional racism in the sense that they operate to deter racial minorities, hinder access to benefits and services, or are unresponsive to their needs.

The above are some general characteristics and situations of refugees. In designing needs assessment strategies, the specific characteristics, experiences, and situations of particular groups of refugees, e.g., Laotians, Cambodians, Vietnamese, Hmong, ethnic Chinese, Cubans, Ethiopians and Haitians, must be understood and kept in mind.

C. Needs Assessment

1. Definition. For the purpose of this project and Task II, Needs Assessment, the term "needs assessment" is taken to mean the assessment of the needs of groups, communities, target populations, and organizations as a tool of planning, policy analysis and development, management, resource allocation, and program evaluation. Specifically, we are concerned with the mental health needs of the various refugee

populations and the extent to which these needs are or are not met, by either informal support systems or by formal systems in govenment, industry, and the private non-profit sector.

The above definition is to be distinguished from clinical assessment for clinical purposes, that is, for particular patients or families and small groups under treatment in service agencies or private practice. Thus, clinical practitioners employ many assessment tools -- MMPI, psychological tests, "depression scales" and the like, to aid them in their clinical practice, but this meaning of assessment should not be confused with the policy and management meaning of the term. However, many clinical assessment tools can be used or be adapted for use in policy-management needs assessment, particularly if the instrument is simple, easily-administered, and readily scored and interpreted. For example, a simple scale that has been found to be reliable and useful in diagnosing depression among Southeast Asian refugees, a common problem, might be administered to a sample of refugees as part of a survey of refugee mental health needs. Moreover, the scores might be aggregated for the total caseload. However, the objective would be to obtain a profile of the nature and incidence of depression in a given refugee population and the extent to which the need is met or not met, not whether a particular patient suffers from depression.

2. Convergent Analysis. It is assumed that no state program will depend on only one method of needs assessment. Rather, it is assumed that each state program will employ a combination of methods of assessing refugee mental health needs. The selection of methods will depend on such factors as purpose, resource and time constraints, and accuracy requirements. The evidence collected from these several

sources will then be expected to converge or point to certain conclusions that can be used in the planning and decision-making processes of the state agency.

II. PURPOSES OF NEEDS ASSESSMENT

The purpose of needs assessment is to secure information to answer the following questions: 1) who are the individuals and families about whom there is concern, i.e., the target population; 2) what are their needs and problems; 3) to what extent, where, how and by whom are these needs being met; and 4) what needs are not being met and why?

Although the purpose of needs assessment is self-evident -- to secure information about the needs of specified communities and groups -- because such information is of actual or potential value to a variety of actual or potential users who have different perceptions of need and different perspectives on how information is to be used, needs assessment strategies must begin with purposes as defined by the several audiences or users of the information.

A. Policy-makers. -- These include legislators, executives, and political appointees who make the major policy decisions on goals, the allocation of resources, and the political aspects of a program. They make a basic value judgments. Information generated by a needs assessment may confirm or support a political decision or be used to influence political action.

B. Administrators and managers. -- These include the top and middle managers who are responsible for planning and directing the operations of the organization and who depend on information to make their decision. They have an organizational perspective and are

concerned with questions of effectiveness, efficiency, and conformity with established policy. Since they are concerned with choices and, therefore, with rationing, their need is for information that will enable them to make such choices more rationally and systematically. A needs assessment may disclose vast unmet need but unless that need falls within the function of the agency or the information is in such a form as to be useful for decision-making, it will be of only academic interest. The information has to be useful for management purposes, that is, for planning, resource allocation, program development, or evaluation.

C. Planners. -- Information is crucial to planners and the planning process, whether that planning be operations or program planning or basic or long-range planning. Needs assessments provide the empirical basis for the rational planning process. Program planners may need a different kind of information than do long-range planners. The former are concerned with current and day-to-day operations, the latter with long-range trends and the future.

D. Clinicians. -- Although clinicians are concerned primarily with their clients and patients, they practice within a context of community services and a network of linkages that may or may not be supportive of their clients or have gaps and overlappings that adversely affect their clients and their practices. Even though they practice with individual clients and patients and have a clinical perspective, clinicians have to be knowledgeable about the cultures from which their clients come, their general needs, the support systems through which these needs are met, and the shortcomings in services that adversely affect their clients.

E. Advisory committees and groups. -- Most groups -- the aged, blind, disabled, families with mentally retarded members -- form self-help or interest groups or associations. Self-help groups and mutual aid associations are particularly numerous and significant for refugees. Many are also political action and advocacy groups as well. Information generated by needs assessments will be of interest to such groups, however they see their missions and purposes.

F. Consumers. -- These overlap with interest and self-help groups. They may or may not become pressure and advocacy groups. If the goal of a program is to involve consumers more directly in the programs, needs assessments operate in various ways to encourage such involvement: by providing them with information on availability of services and by engaging them in the surveys. Indeed, refugee surveys often can be accomplished only with the cooperation or acquiescence of the groups and consumers. Some needs assessment techniques often serve a dual purpose, such as when a public forum or hearing, ostensible to attract a sample of respondents for data gathering purposes, turns into or is used as a take-off for social or political action. Some needs assessments may be self-assessments, for such purposes as neighborhood improvement.

Thus, one approach to designing a needs assessment is to consider the actual or potential users which, in turn, will indicate the thrust of the needs assessment, the type of information that will be gathered, the individuals or groups to which it will be distributed, and the uses to which it will be put. A systematic consideration of users also will suggest members of an advisory committee to the needs assessment. it is not likely, unfortunately, that any one needs assessment will satisfy all users; hence, a systematic examination of actual or potential users

will at least make a rational choice possible and enhance the value of the survey. The needs assessment can then be targeted to the information needs of specific users and user groups.

When planning the refugee mental health needs assessments, state programs might well consider whether their needs assessments are to serve as benchmarks. This view of needs assessment implies:

1. That a series of assessments, rather than one, will be done over time.
2. That the purpose is to examine trends in need, as well as need at a given time.
3. That needs assessment data will be used directly or indirectly for program evaluation purposes.
4. That the methods and instruments of data collection will remain reasonably uniform through the several assessments in order to assure comparability.

The benchmark view of needs assessment is an obvious and laudable one but it poses issues and obstacles that make it problematic. The first obstacle, of course, is the one of cost. Needs assessments are time-consuming and costly at best. It is unlikely that most agencies would be willing or able to commit themselves to a series of needs assessments. On the other hand, there is need for data that show trends. Program evaluation -- as measured by effect and effectiveness -- also is a difficult proposition at best. Since needs assessment data are often expressed in the form of rates, an increase or decrease in rates could mistakenly be attributed to the effectiveness or ineffectiveness of services and the service delivery system. Unfortunately, causality is not very well established in mental health

and causal models are very primitive in program evaluation. Rates are influenced by a myriad of known and unknown variables, and many if not most are beyond the control of the service delivery system. Finally, the benchmark view of needs assessment assumes that uniform methods and instruments of data collection will be used consistently over the series of assessments. Although some rough comparisons can be made across programs at any given time, and over time within any given program, it is very likely that the methods and tools of data collection will vary widely among programs and over time within an organization. A basic problem is that such tools as questionnaires and interview schedules are still in their developmental stages in respect to the several refugee populations. This situation is likely to continue for some time and will make trend analysis less than precise.

Despite the problems of planning for and conducting needs assessments over time, it is suggested that state refugee programs give some consideration to the benchmark view of needs assessments and weigh its benefits against the additional costs.

III. CONTEXT OF NEEDS ASSESSMENT

Assuming that the purpose of needs assessment in the refugee mental health program is to assess the mental health needs and problems of the refugee populations, the areas and extent of unmet needs, and gaps in the service delivery system so that appropriate and effective services to prevent and treat mental health problems among the refugees can be developed, needs assessment is viewed as a means of establishing an empirical basis for the rational planning process. Since the goal is to affect the service delivery system so that it becomes more responsive

and meaningful to the refugee populations, the state programs need to examine their own service delivery systems.

A general model of a service delivery system might be constructed along the following dimensions or variables. Each state can ascertain the variations along each variable and decide if and how these variations affect the provision of services to refugees, positively or negatively, and if and how they might be changed. In effect, this will be an assessment of the state's refugee mental health service delivery system.

A. The System's Environment. -- This includes the characteristics of the community within which the delivery system operates: the historical, political, social, demographic, economic, attitudinal and other factors that impinge on the agency. Some communities are tolerant and receptive to newcomers and differences, others are not. The political and administrative climate may or may not be liberal and progressive and may or may not be supportive of education and social services. The state of the economy and the kind of industries will have a bearing on the capacity of service agencies to provide services. Demographic factors such as age, education, income, diversity, and mobility also will influence agency policy and operations and the capacity and willingness of a community to absorb an influx of refugees. Finally, delivery systems operate in the context of a network of community resources -- public, private, sectarian, and profit-making -- that constitute a support system. Often overlooked are the increasing volume and variety of mental health and social services available through Employee Assistance Programs (EAPs) in industry and governmental or non-profit organizations.

Data on the delivery system's environment are readily available. The more subtle attitudinal and political factors also generally are known or sensed by staff, community leaders, and the refugees themselves.

B. The Rules. -- Rules determine who is to be served, by whom, in what way, at what level, and on what terms. They mandate, prohibit, and permit. Rules may be classified as follows:

1. Statute. -- The basic rules that authorize and fund programs. Federal rules include the refugee assistance statutes. Ordinarily states also must enact statutes to take advantage of federal grants. As part of their assessments, states might examine their statutes pertaining to refugees in order to identify their strengths and shortcomings and any provisions that inhibit services to refugees.

2. Administrative procedures. -- These are the rules and regulations issued by administrative agencies, such as the departments of human services, that implement and delineate the broad mandates of legislation. They may interpret the statutes liberally or restrictively and may contain provisions that restrict refugee services or support front line staff or unduly restrict them. Since administrative procedures are promulgated by administrative agencies, they are amenable to change by staff within the administrative process.

3. Case law. -- Rules established by the decisions of the courts, primarily the appellate courts, become binding on administrative agencies. Although the volume of case law specifically applying to refugees appears not to be large, case law is becoming increasingly important in social welfare because services often involve an infringement on individual rights in the public interest or involve

Constitutional issues. Since case law arises out of litigation initiated by lawsuits, the explanation for the lack of case law involving refugees may be a function of refugee reluctance to challenge. However, refugee status and refugee assistance involve many legal issues and some issues can arise out of cultural differences (for example, the definition and handling of child abuse and family violence). The direction seems to be toward more explicit legal rights -- of children, parents, victims, consumers, adult and juvenile offenders, and patients and clients. In time, there could be more litigation involving refugees.

4. Conventions. - The habits, practices, methods of the individuals and groups engaged in the provision of services. Many of these rules are understandings: informal and unwritten structure, policies, and procedures that can be very finding on staff. All organizations have personal, informal structures, policies and procedures as well as formal ones. They are influenced by the attitudes and preferences of staff at all levels and, in turn, can influence practice with patients and clients. An executive can create a climate that is punitive and deterrent; he or she can, in subtle ways, move the agency toward an elitist, highly selective service, or toward one that is understanding of such groups as refugees. The informal rules may emphasize highly therapeutic treatment or prevention. The "informal" organization, therefore, can significantly affect whether and how an agency serves refugees and how accessible and appropriate its services are. Although the informal system often is difficult to study systematically, it has to be considered in any assessment of a service delivery system. In any given professional community, there is an

awareness of the climate of administration and service in any given agency. The same is generally true of user communities, such as refugee communities, which quickly sense acceptance and service appropriateness. In any event, conventions are a variable in any assessment of service delivery systems because they are factors that influence accessibility, availability, and appropriateness of services to refugees.

C. Administrative Structure. -- The organization of the system and the way its parts fit and function together. Some organizations may have distinct separate units for refugees; others may serve refugees through the regular units that serve all populations. Some agencies are highly centralized in decision-making; others have decentralized decision-making. Some organizations emphasize specialization; others are built around generalist functions. The administrative structure influences the way an organization's programs and staff are directed, coordinated, and integrated. Some use case managers to coordinate the staff and services; others coordinate by procedures. Information and referral services may help a refugee. Administrative agencies have grown increasingly complex and it is not uncommon for a patient or client to get lost in the complexity. Even staff often are unable to navigate the complexities. Attention has to be paid to these linking mechanisms. What, to a non-refugee, may be a simple oral or written referral, can be an insurmountable barrier to a refugee. Explicit instructions, even a personal escort, may be necessary.

D. Financing. -- Obviously, financing will directly affect the availability and appropriateness of mental health services for refugees. Available resources are not always used most efficiently and effectively. Financing formulas and provisions may adversely affect or

restrict program operations. For example, financing may emphasize or encourage institutional or residential care but make community and home based care and services less available. Or, conditions attached to aid or services may be perceived as demeaning or deterrent.

E. Facilities and equipment. -- Location, adequacy, appearance, and office hours may be factors in accessibility and utilization. Facilities also may influence staff performance and efficiency.

F. Programs. -- The benefits and services provided, their quality and quantity, availability and appropriateness. These are the things with which most refugees will be concerned. An inventory probably is already available and may point up gaps in service, especially when combined with needs assessment information.

G. Staff. -- The quality and availability of services in human service delivery systems depend heavily on the quality, quantity, preparation, and training of staff. With respect to refugees, an added factor is the ability, willingness, and availability of staff to deal with refugee-specific needs and problems, of refugees who come from differing cultures and who are non-English speaking.

H. Consumers. -- The users, actual and potential, of the services of the delivery system. The states' assessments of refugee mental health needs are designed to provide information on the characteristics, resources, needs and problems of the refugee populations that make up the consumer population. The needs assessments will also throw light on the extent to which refugee mental health needs are met by the existing service delivery system and the extent to which gaps exist and needs are unmet.

Thus, although refugee needs assessments are directed at the refugees, how useful the needs assessments are will depend largely on the extent to which the information gathered bears on the service delivery system in general and on particular aspects of the system. Assessment of the service delivery system and assessment of refugee mental health needs can proceed concurrently, keeping in mind that the ultimate purpose of refugee needs assessment is to affect the delivery system in specific ways. Needs assessments are conducted for a variety of purposes -- planning, management, evaluation, political, to improve efficiency, to identify gaps in service, to target services. All bear directly on the service delivery system or particular components of it.

IV. MODELS OF NEEDS ASSESSMENT

In this section will be enumerated and discussed the major models and methods of needs assessment that state programs may employ, together with comments on their relevance and appropriateness for assessing the mental health needs of refugees. These are general comments. Currently underway is a survey of specific tools of needs assessments, such as questionnaires, appropriate for use with specific refugee groups. Also underway is a survey of needs assessments conducted by the states and counties, by private organizations such as the Pacific-Asian Mental Health Research Center, and by university investigators. The results of these surveys, both of findings and methods, will be distributed to state refugee programs as part of the Technical Assistance Center's "broker" role.

As discussed above, it is assumed that the states, in planning their needs assessments, will have taken into consideration the general

characteristics and situations of their refugee populations, will proceed with an assessment of their own service delivery systems along the various dimensions or variables of the model as suggested above, will employ convergent analysis of information secured through several methods of gathering data, will systematically examine the actual and potential users of the information generated by the needs assessment and their specific information needs, and will then target their needs assessments to specific refugee populations, to sub-populations within the group such as the aged, youth, families, children, and to specific kinds of information for specific users.

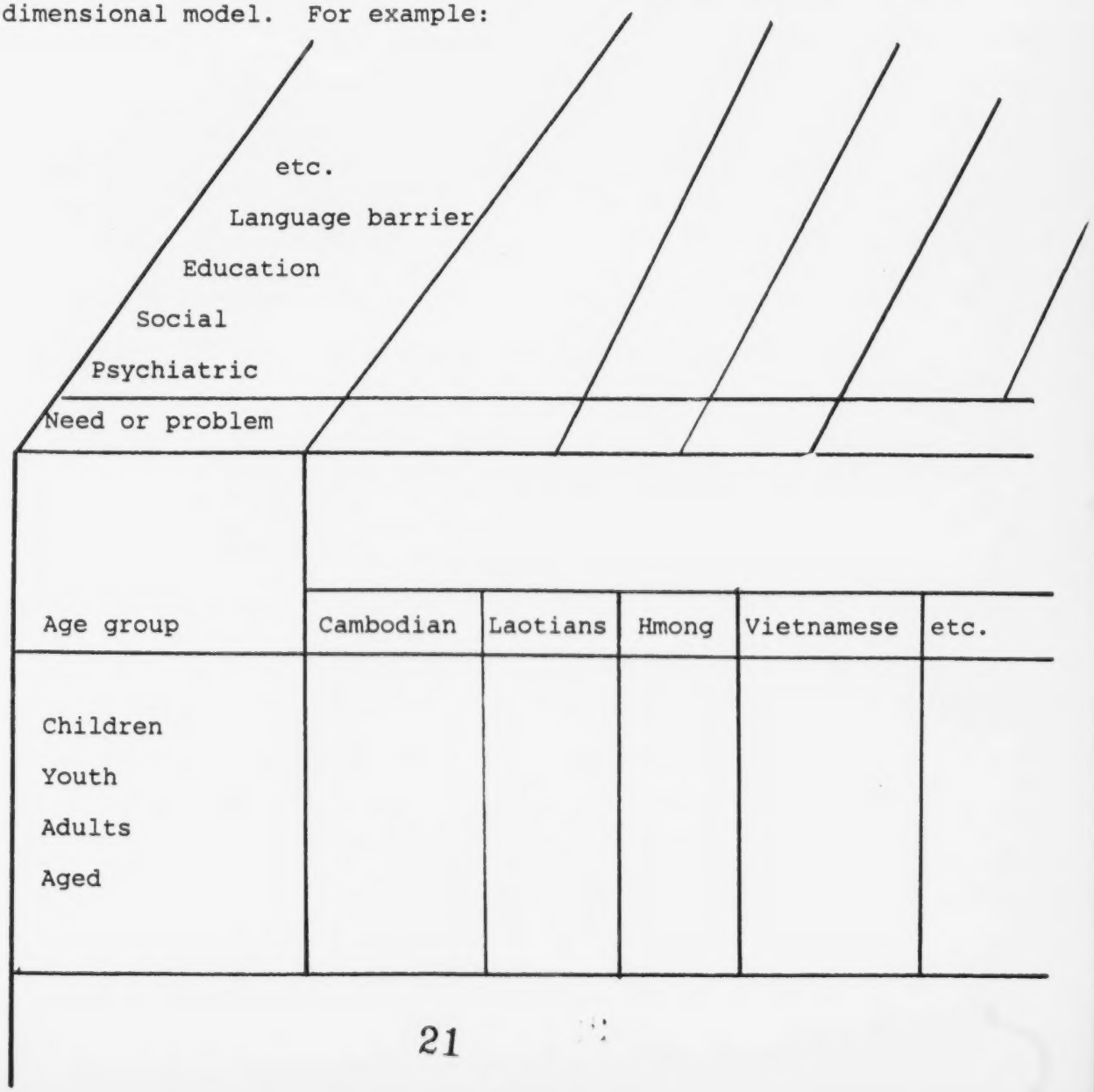
In any given community, the pattern of mental health and social services tends to follow a more or less logical functional organization usually based on specialization, whether by kind of service or benefit (for example, financial aid, health, housing, legal services, family and children's services, protective services, mental health), clientele group (such as children, preschool and school, youth, adults, and the aged), or problem (such as mental illness, delinquency, alcoholism, mental retardation). This functional organization exists both within and among the various service organizations in a community.

The refugee needs assessment can be designed with the total service delivery system of a community in mind or with respect to a particular aspect of the system or particular agency. To undertake a needs assessment without first systematically considering users of the information, the specific kinds of information needed by each user group, and the specific aspect of the service delivery system the information can be expected to affect may result in a "broad brush" approach that gathers only general information that is not specific

enough for specific users for specific purposes or one that generates specific information but leaves out needed information.

For this reason, it is advisable and customary to form an ad hoc committee made up of users and others who have an interest or stake in the outcome of the needs assessment.

Once the specific users and kinds of information sought are established, the information to be collected might be visualized as a three-dimensional model. For example:



To the extent to which time and resources permit, data collection instruments can be designed to collect data on any or as many of the dimension on which data are needed. Moreover, since needs assessments are intended to throw light on how needs are met as well as on unmet need and gaps in the delivery system, the variables under "need or problem" should be further specified as to: 1) where the need is met, how, and by whom and 2) if the need is unmet, where and why the gap in the delivery system exists.

A. Social Indicators. -- This approach employs secondary analysis of existing data and usually can be done expeditiously since most of the data already exist in readily available data banks, as often as not in computerized form. Secondary analysis can provide two kinds of information: 1) general background data, for example, on demographics, unemployment rates, dependency rates, and mortality and morbidity rates from which can be inferred the needs and problems of specific populations, including refugees, or which provide a basis of comparison between refugees and the general population, and 2) refugee-specific data on demographics, income, employment and unemployment, mobility, residence, crime and delinquency, and family dissolution.

Unfortunately, refugee-specific data may not be very extensive or refugees are not identified in sufficient detail (e.g., they may be classified s "aliens" or "others" without a finer classification of country or locality of origin or of racial or ethnic background). Nevertheless, the social indicator method through secondary analysis should be considered the first step. It can be done quickly, it can generate large amounts of data, especially if several data banks are tapped and the data are combined, and it can show general patterns that

suggest specific areas for more elaborate needs assessments. It is assumed that state refugee programs are already well familiar with the social indicator approach and have access to the various data banks through their own research units or those of the department of which they are a part or such units as a state planning agency. Sources of data include: census data, social security data, employment data from the state employment offices, and data from public assistance offices, health and welfare council and United Ways, state demographers, state planning departments, courts, and university surveys.

B. Key Informant. -- This technique relies on information gathered from individuals who are presumed to be knowledgeable about the needs and problems of the groups under study. It is used for two purposes: 1) as a quick and usually very helpful method of gathering information, quantitative and qualitative, and 2) as a preliminary step toward more elaborate and systematic data gathering. "Quickie" surveys usually can be completed by a few telephone calls to key informants who generally are well known in the community and to the investigators. Otherwise, the usual approach is "reputational," i.e., starting from one contact, he or she is asked for the names of others who might be knowledgeable and the process is repeated until the field has been reasonably covered. The "reputational" method is often used in ascertaining the power structure of a community. An advantage of the key informant method is its ability to secure in-depth information on particular aspects of the inquiry. Illustrative cases, often anecdotal, can be uncovered and, for some purposes, such data can be as useful as quantitative survey data. Also, key informants usually have a wealth of information that ordinarily is not or cannot be collected in formal surveys, especially

when they are willing to speak "off the record," as many are. In such cases, care must be exercised to insure confidentiality. Even if the information cannot be used, it often suggests kinds of information and points to other sources.

The disadvantages of the key informant method lie in the biases of the informants. Most have an axe to grind, a point of view to promote, or a position to defend, To control bias as much as possible, it is essential that the list of informants be carefully made up to include individuals on different sides of the question, at different levels, and from different perspectives. The tool of data collection can be face-to-face or telephone interviews or mailed questionnaires and can be structured or unstructured, depending on the nature of the information sought, the respondent, and the purpose to which the information will be put. Non-structured interviews may produce more detailed data and permit probing but are likely to be more biased and less uniform. Structured questionnaires and interview schedules will be more uniform but tend to restrict probing and open-ended discussion.

With respect to refugee needs assessment, a "snowball" technique might be used to develop a list of key informants as well as to collect data. Starting with a small number of obvious informants, each is asked to suggest additional informants from which the final list of informants can be selected on a more systematic basis, they to be interviewed or sent questionnaires on some kind of specified sampling basis, whether purposive or random.

Key informants who might be sources of information on refugee mental health needs include:

1. Professionals within the delivery system who are known to be knowledgeable about refugees: unit supervisors whose units come in contact with refugees, program directors, workers whose caseloads include refugees. Public assistance programs often include supervisors and workers who are knowledgeable about refugees because a high proportion of refugees are recipients. Child protective services often have cases of suspected neglect or abuse reported to them. Larger departments often have specialized units to deal with minorities and come into contact with refugees. Community mental health centers may serve refugees and often have professionals who have developed a special interest or expertise in refugees. Such centers often employ bilingual refugee staff.

The professional communities -- psychiatrists, pediatricians, social workers, nurses, psychologists, and related health and social service professionals -- can be systematically canvassed as to possible key informants.

The voluntary sector (e.g, Lutheran Social Services and Catholic Social Services) has sponsored refugees and developed programs for refugees. The staffs include many who have considerable expertise in refugee matters and many bilingual workers.

Schools, housing projects, and the police regularly encounter refugees. Often they have staff, some bilingual, who can contribute information; many have special units to deal with minorities, including refugees. Pre-school programs, such as Head Start, enroll refugee children and actively engage parents.

University faculty who have conducted studies of refugees or who have a special interest in refugees -- sociologists, anthropologists,

linguists, social workers, and public health and medical school professors -- can be identified through their publications; usually they are well known locally for their interest in refugees. Other researchers include staff of such centers as the Pacific Asian Mental Health Research Center in Chicago, from whom information can be secured, through interview, or through their reports and publications.

Specialized agencies serve immigrants, foreign students, and minority populations such as International Houses, International Student Centers, and various "cultural centers" that serve refugees.

The refugee populations themselves provide much of the important data and key informants should be sought from these populations. Most refugee groups have associations, some formally organized, others loose associations. Their leaders are usually well known, to agency staff and to members of refugee groups. Among other things, they view refugee needs and the reasons such need is met or unmet from a perspective that differs from that of agency staff. Their information and views will help balance off the perspectives of the non-refugee informants. The "snowball" technique usually works well in seeking out informants from refugee populations.

State refugee programs undoubtedly are already familiar with these sources of information and need only to develop a more systematic method for sampling the various populations to identify the key informants from whom to secure information and to devise the methodology of data collection, that is, telephone or face-to-face interview, questionnaire, and the content of the interview or questionnaire. As indicated above, the content will be largely determined by the use to which the information will be put and by whom it will be used. Key informants

often are able to provide information on the utilization and appropriateness of services, the reputation of services in the refugee communities, and the gaps in service and reasons for non-utilization.

Although the key informant method may be viewed as an end in itself, that is to collect specific kinds of information from specific informants to be used for specific purposes, more likely it will be instrumental to three other objectives: 1) To explore and identify the kinds of information that will be gathered by other methods; 2) To gain access and acceptance to the target population, in particular, the refugee populations; and 3) To refine and test sampling procedures, questionnaires and interview schedules, procedures and other aspects of design and method. Pilot testing is indicated in any study; it is crucial in studies of refugees who may or may not be English speaking and who probably come from an entirely different culture. Informants usually will readily volunteer suggestions about the kinds of information that might be helpful in understanding refugee needs or will indirectly suggest questions during the course of the interview or on the questionnaire. Key informants, particularly from the refugee populations, ordinarily are key figures in the community and thus often are the key to access. This is particularly true for refugee communities since most are not large and usually are held together by personal relationships, for example, in the Hmong communities. The success or failure of a survey may depend on the go-ahead of a community leader who, in most cases, will be one of the key informants. Moreover, in respect to certain methods of needs assessment, for example, the public forum method, the cooperation and support of key community leaders may be essential in attracting a sample of respondents.

C. PUBLIC FORUM. -- This method is essentially similar in principle to the public hearing commonly held to disseminate information and to gather evidence and views on matters of public policy or in respect to a particular incident such as an airplane disaster. Informants are invited, or required, to present testimony for the record. Although an effective method of assessing need, it has drawbacks, especially for assessing refugee need. Testifiers usually have a vested interest in the hearings' outcomes. Representatives of provider organizations tend to dominate hearings. If representatives or members of user or community groups testify, they usually are from groups that are articulate and well-organized, such as those of senior citizens, retired persons, the blind and disabled, and the mentally ill and mentally retarded. Experience has shown that members of refugee groups are reluctant to speak up at public forums. Nevertheless, the public forum should be regarded as an important component of the state's needs assessment strategy. It will be successful, however, only as key community leaders are enlisted in the effort, its purpose is made clear, and there is considerable advance publicity. In all probability, most of the testifiers will be from the list of the key informants and their participation may encourage others to contribute their views.

The public forum also has been demonstrated to be an effective way of gathering a sample of respondents to fill out questionnaires or respond by show of hands to questionnaire items that were read to them. (For example, Indochinese Refugee Community Needs Assessment, John M. VanDeusen and Jay Lappin, Philadelphia Child Guidance Clinic.) Inevitably, the sample will be biased, of course, but the information collected can be substantial and valuable. Public forums also are

effective parts to self-assessments, e.g., when a refugee community undertakes a neighborhood improvement project or a community education project on child-rearing.

D. RATES IN SERVICE. -- This method attempts to estimate need on the basis of the number and characteristics of a particular group served by existing programs. The method assumes that a reasonable estimate of the need among a given population can be derived from an enumeration and analysis of individuals currently served. Obviously, this is a challengeable assumption since the number and characteristics of an active caseload may be influenced by highly selective factors that make the service caseload entirely different from the target population. Nevertheless, data on rates in service usually are readily available, often in considerable detail: the demographics of the clients, problems with which they have sought help, kind and duration of service, referral source, and outcomes of service. Agencies typically publish these data in reports or the data are part of management information systems from which they can be retrieved and analyzed. For the purposes of the refugee mental health project, however, refugees may not be identified specifically as such or the identification may involve reading of the case records, ordinarily a time-consuming process.

Some indication of unmet need often can be ascertained or inferred from data on source and circumstances of referral and from outcome data. That is, a refugee might be referred from another agency because it is unable or unwilling to be of assistance or the case was closed because the client did not return despite obvious need or the agency was not able to be of help because of limited resources or unavailability of staff equipped to deal with the refugee's particular problem.

A variation on the rates in service method are studies of clinical samples, e.g., studies of Southeast Asians who are patients at a mental health center that serves a large number of such refugees. Although the data are gathered from a highly selected sample, those who are referred to or come to a specialized mental health service for treatment, the data do enable one to speculate about the mental health needs and problems of the non-patient population and the kinds and severity of mental problems that could be reasonably be expected to be present. (J. Westermeyer, T.F. Vang, J. Neider: Refugees Who Do and Do Not Seek Psychiatric Care: An Analysis of Premigratory and Postmigratory Characteristics, Journal of Nervous and Mental Disease 171, 1983).

By the same token, data from Information and Referral Services and similar organizations may show a pattern of numerous requests from individuals and agencies but inability to refer to appropriate community resources. It can be assumed the i and R and similar services will be highly sensitive to refugee need and unmet need and may be able to provide statistical data that is refugee-specific. At the least, I and Rs can provide impressionistic information that may be quite valuable.

Thus, although the rates in service method may not accurately estimate need among specific refugee groups, it can give some indication and as a first step in needs assessment it is a quick way to establish what is known. It also can be part of comparative analysis, that is, rates in services compared across states, localities, services, and organizations and for particular refugee populations as compared to the majority population will show patterns of utilization that point to areas of unmet need and gaps in the service delivery system.

E. SURVEYS. -- This method, perhaps, is the most scientific in the sense that the design, sample, method, and instruments of data collection are likely to be under the control of the investigator and the data can be analyzed systematically, probably statistically. Survey methods and designs are well known and tested. There is no need to discuss them here. What is important is to recognize that the refugee populations differ from the general population and among themselves because of circumstances of migration, country or locale of emigration, culture, language, duration of residence in the U.S., progress in adjustment or assimilation, concept of illness and mental illness, and views on treatment. These differences have to be taken into consideration in planning the survey and in designing the data collection instruments, whether questionnaires or interview schedules. If questionnaires, the questions need to be thoroughly pre-tested for language and content, translated and back-translated. If interview schedules, the same would apply and interviewers need to be bilingual and thoroughly trained.

There is now sufficient experience with surveys of groups that differ culturally from the majority to conclude that surveys of refugee groups can produce reliable and valid data, especially when survey data are combined with data generated by other methods. For example, the Santa Clara County Health Department conducted an Asian Health Assessment Project that incorporated a mental health assessment of Cambodians, Vietnamese, Chinese refugees, and nonrefugee Chinese resident in Santa Clara County, California. (K. Meinhardt, S. Tom, P. Tse, C.Y. Yu, Santa Clara County Health Department Asian Health Assessment Project, 3 August 1984.) In the survey, a detailed

questionnaire was used, containing questions in the following categories:

1. General personal characteristics such as age, sex, income, etc.
2. Health status, physical and mental, as perceived by the respondent.
3. Employment and disability.
4. The network of friends and relatives, as a support system.
5. Psychological distress and dysfunction, arranged in five scales: health opinion, anxiety, depression, cognitive impairment, and psycho-social dysfunction.
6. Refugees' war experiences.
7. Information about the interview itself, such as length, number of items refused, etc.

The questionnaire was translated into the three Asian languages. Chinese and Vietnamese were interviewed by phone, the numbers drawn at random from the phone directory. Cambodians in a random sample were interviewed in person. Only 5.6 percent refused to be interviewed.

During a public forum to which Indochinese refugees were attracted by the showing of a movie depicting the migration of Indochinese refugees, respondents filled out questionnaires as part of a needs assessment project (J.M. VanDeusen and J. Lappin, Philadelphia Child Guidance Clinic). Social support and alienation among Vietnamese living in Texas and Oklahoma were investigated by use of a questionnaire written in both Vietnamese and English (Thanh V. Tran, Social Support and Alienation among Vietnamese Americans: Implications for Refugee Policymaking and Resettlement, Ph.D. Dissertation, University of Texas, Arlington, May 1985). A sample of 117 Cuban exiles living in Harris County, Texas, were interviewed, using a revised form of the Homes and

Rahe Scale (Social Readjustment Rating Questionnaire) to ascertain areas of stress in cultural readjustment. (T.M. Valdes and J. C. Baxter, the Social Readjustment Rating Questionnaire: A Study of Cuban Exiles, Journal of Psychosomatic Research 20, 231-36, 1976.) The questionnaire was translated into Spanish and back-translated, and respondents were interviewed in their own homes.

Thus, the evidence points to the conclusion that survey methods can be used with confidence to assess refugee mental health needs and that survey techniques should be an integral part of states' refugee needs assessment programs.

Field Studies. -- Although field studies are not usually specifically designed to ascertain need, such studies as conducted by social scientists often throw light on unmet needs of the population studied and the field study can be used as part of a needs assessment program. Field studies involve the systematic examination and analysis of a given community or population following a model of analysis that prescribes the categories of information that is to be collected through examination of documents, interviews, and observation. A specific form is the participant-observer study. Agency staff and others who come in contact with refuge populations become familiar with such communities -- their structure and dynamics -- and often are able to ascertain areas of need. Although the field study may not be incorporated into the needs assessment strategy, state agencies can enlist observers who are familiar with the refugee communities in their needs assessment studies. Such observers might also be considered key informants.

V. DATA ANALYSIS

In analyzing data gathered through needs assessments, some considerations should be given to the various definitions of need because how need is defined will influence how the needs assessment data are interpreted and used.

A. Felt Need. -- When needs or problems are perceived by the individual as discomforting or disabling, they may be expressed as demand. It could be said that rates in service represent demand although there may be unmet demand as expressed in the form of waiting lists or those denied service for technical reasons such as eligibility requirements or the unavailability of services.

B. Normative Need. -- This is need as defined by experts who base their judgments about need in a given population or community on formal or informal standards, norms, or expectations. Thus, for a given population of mothers who are working, it is possible to estimate the number of day care slots that should be provided. Similarly, given a specified population, experts can estimate the need for hospital beds of certain types. In like fashion, it is possible to estimate the need for mental health services, the number and kinds of staff, and the location of facilities to serve a given population of catchment area. Such judgments, obviously, are not an exact science; they are the informed guesses of knowledgeable persons and assume norms of some kind.

C. Comparative Need. -- Comparative analysis may offer the most useful approach inasmuch as the Refugee mental health program is concerned with a population whose culture, characteristics and needs differ markedly from the general population, its members require special and unique forms of services that existing systems may or may not be

able to meet or are not meeting, and there are fewer norms on which to base judgments.

Comparative analysis involves the examination of specified objects or phenomena on specified variables or dimensions across different programs, localities, or countries. Such analysis broadens perspectives; offers alternative models, approaches, and methods; and shows strengths and gaps in services and service delivery systems. Thus, if there are three mental health facilities in a community and only one has a caseload that includes refugee patients and the one clinic has a waiting list or turns away patients, obviously there is an unmet need in the community. This comparison then becomes the basis for an examination of reasons, which can range from legislation, financing, staff attitudes, or inaccessibility. If a given service is judged successful with a specified group of refugees, it is logical to compare it with other like services.

Since the thrust of the Technical Assistance Center's Needs Assessment Task and the needs assessment strategies of the states is to identify and remedy gaps in the service delivery system, it may be helpful to juxtapose data gathered by the various needs assessment methods along the several dimensions or variables of the model of the service delivery system. One model has been delineated in Section III, above. The model can be modified by the states to fit their own concept of a service delivery system.

A matrix can be constructed as follows:

State, Program, Agency, by Variation

Dimension or variable	X State or X Program	Y State or Y Program	Z State or Z program
Environment			
Rules			
Administrative Structure			
Financing			
Facilities			
Programs			
Staff			
Consumers			

The variations can be indicated in the cells, thus enabling a comparative analysis. Data may be descriptive in whatever detail is desired or the variations can be presented in scale form, e.g., adequate-inadeqate, or presented in problem form that identifies and describes the strengths, gaps, and limitations along each variable. The major variables can be broken down into sub-variables -- for example, Staff: bilingual; and programs can enumerate the various services offered -- and be compared across agencies, programs, states, and communities.

Short of comparative analysis, it may be helpful for the state programs to use this approach to assess their own programs along the same variables or those of some other model of a service delivery system.

SELECTED BIBLIOGRAPHY ON NEEDS ASSESSMENT

Note: Bibliography does not include general works on survey design and method, questionnaire construction, sampling procedures, and interview techniques. It is assumed that such literature is already available to state refugee programs.

GENERAL ITEMS

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A neighborhood-based needs assessment to enable a neighborhood to plan and develop neighborhood programs. Example of a community self-assessment for social action to improve the neighborhood. Suggests a model for refugee associations to use for social action purposes; professional's role is that of catalyst and facilitator.

Hardiman, Margaret, Social Surveys and Social Planning. Chapt 3 in The Fields and Methods of Social Planning, edited by James Midgley and David Piachaud. New York: St. Martin's Press, 1984, 56-86.

General discussion of social surveys, purpose, methods, and design and their use in social planning, with examples of instruments, and applications in household surveys in Nigeria and a housing survey in Britain.

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Social functioning is defined as human behavior in social roles and contexts, a person's activities and relationships. Report is a survey of literature on methods of measuring social functioning in mental health, a listing of instruments designed to measure social functioning, and a critique of each instrument, the content, measurement strategy, and psychometric properties.

Mayer, Robert R. Assessment of Need. Chapt. 7 in Robert R. Mayer. Policy and Program Planning: A Developmental Perspective. Englewood Cliffs, NJ: Prentice-Hall, 1985. 125-36.

General discussion of needs assessment as providing the empirical basis of the rational planning process; the concept of need; nature of needs assessment; factors that block assessment of need; program inventories; sources of data; techniques of assessment.

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General discussion of social statistics and social indicators as measures of social conditions and their use in social planning. Illustrative applications in Britain and India.

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Kansier, Chris; Williams, Linda; Giel, Debra; and DeMarre, Nancy. The Hmong in St. Paul: A Culture in Transition. Community Planning Organization, Inc., 333 Sibley St., St. Paul, MN 55101; May 1980.

A descriptive study of the Hmong population in St. Paul. General discussion of Hmong in SE Asia, family structure, migration, beliefs, including health; adjustment in St. Paul, including housing, employment, social services, and other effects of resettlement. Need indicated for language training, help in integrating, education, acculturation; and activities of the Hmong Association.

Matsuoka, Jon K. Vietnamese in America: An Analysis of Adaptational Patterns. University of Michigan Ph.D. dissertation, May 1985.

Adjustment patterns of Vietnamese refugees are similar to those of previous Asian American groups in terms of cultural conflict and acquisition of employment and English; aspirations of parents for children; concern about children's retention of traditional values. Adjustment problems were more numerous among older, nonmarried, educated, members of Eastern religious groups, and nonChinese ethnic Vietnamese.

Meinhardt, Kenneth; Tom, Soleng; Tse, Philip; Yu, Connie Young. Santa Clara County Health Department Asian Health Assessment Project. San Jose, CA: Mental Health Services, Santa Clara County Health Department, 2220 Moorpark Ave., San Jose, CA 95128.

Needs assessment of Asian groups--Cambodians, Vietnamese, Chinese refugees, and nonrefugee Chinese--in Santa Clara County, CA, in 1979 using epidemiologic methods, including rates under treatment, social indicator, and community survey techniques. Detailed questionnaire, translated into three Asian languages, included: personal characteristics, respondent-perceived physical and mental health status, employment and disability, support system of friends and relatives; five scales relating to psychological distress and dysfunction such as anxiety and depression, refugee war experience, and reactions to the interview itself. Randomly selected Chinese and Vietnamese interviewed by phone; Cambodians interviewed in person. Cambodians had very high need for mental health services; Vietnamese had significantly higher need than general population; Chinese refugees had much lower need for mental health needs. Five symptom/dysfunction scales used were: The Health Opinion Survey, The Anxiety Scale, The Depression Scale, the Cognitive Impairment Scale, and The Psychosocial Dysfunction Scale. Utilization of health services among refugees, particularly Cambodians is high as compared to the nonrefugee population, including nonrefugee Chinese. A more detailed needs assessment is suggested, for example, to include post-traumatic syndrome component and more culturally-relevant questions.

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evaluation, development and testing of therapeutic and preventive approaches that are effective and culturally appropriate for mental health needs of refugees; encouragement of grouping of similar refugees an facilitation of family reunification; strengthening of indigenous refugee community organizations; strengthening of mental health social agencies to prevent adjustment problems, eg., orientation, language, employment, and counseling and educational programs to develop confidence and self-reliance.

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Study of 426 refugees who underwent comprehensive examination and treatment at Mayo Clinic, Rochester, MN. Health problems identified were primarily selected contagious diseases and stress syndromes with functional complaints. Counseling was necessary in 17 percent for psychosomatic problems or psychiatric disorders. Physicians need to become aware of cultural attitudes and should investigate for infectious diseases.

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VanDeusen, John M. and Lappin, Jay, Indochinese Refugee Community Needs Assessment. Philadelphia: Philadelphia Child Guidance Clinic, May 1979. For permission to copy or quote, write authors at: Resources for Human Development, 120 W. Lancaster Ave., Ardmore, PA 19003.

Community needs assessment undertaken by the Philadelphia Child Guidance Clinic to ascertain what human services are known to and used by Indochinese refugees in SE Region of Pennsylvania: types and volumes of services administered to refugees, refugee familiarity with services, and refugee expression of their own needs. Intent is to improve service accessibility and provision from perspectives of both refugees and providers. Research team included consultants from Indochinese community and fields of psychiatry, anthropology, social work and psychology. Key informants

were used to select set of 36 key services, sample of 111 service agencies were polled, including 35 that provided some services to refugees; to ascertain reasons for inaccessibility and absence or presence of need, and extent to which services were known to refugees. Services were offered in limited fashion in major cities by private providers; many needs were met informally by families and friends. A community forum study was used to ascertain need for services. Respondents were attracted by a television documentary, "Boat People," and, using translators, participants were asked about specific needs, in most cases, by a show of hands. Survey instruments in English and translations are attached to report.

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Study of 97 Hmong refugees in Minnesota, among whom 17 became psychiatric patients over a 12-month period. Sample was developed with assistance of social agencies in Minnesota, Hmong clan leaders, and the Minnesota Hmong Association. Illustrates social psychiatric research that can provide information on the role of interpersonal and societal factors in the genesis of psychiatric disorder. Also illustrates that refugee leaders and refugee associations can be enlisted in support of studies, including needs assessments.